James Skoumal, D.D.S. PC.

1 South 132 Summit Ave, Suite 201 Oakbrook Terrace, Illinois 60181

Financial Agreement

1. I agree to pay the amount charged by the doctor for all professional treatment and services to the undersigned, his/her family or to the patient indicated at time of service.

2. On accounts past due 60 days or more, I agree to ay the doctor a CARRYING CHARGE computed at the periodic rate allowable by law in the state of Illinois…

   Monthly Periodic Rate 1.5% on past due balances (60 days)
   Annual Percentage Rate 18%
   This CARRYING CHARGE will only be applied to balances over 60 days old, after deducting current charges and payments.

3. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for the balance of my dental account regardless of insurance.

4. I can avoid incurring a CARRYING CHARGE by paying my account balance in full upon receipt of statement provided that payment is actually received by the Doctor before the next billing date. This allows for a minimum of 60 days from the date of service to pay my account without incurring a CARRYING CHARGE.

5. If it is necessary for the doctor to retain an outside service to collect any balance due, I will be responsible for all collection costs, attorney fees and court costs.

6. I understand that there will be a charge for any check that is returned.

DECLARATION

I have read the Financial Agreement printed on this form, and I have received a fully complete copy of this Financial Agreement.

_____ _____

Responsible Party or Authorized Member of the Family Date

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HIPAA

Health Insurance Portability and Accountability Act

The law covers a wide range of issues, including:

- assuring portability of health insurance coverage
- a fraud and abuse control program
- creating medical savings accounts
- administrative simplifications provisions, such as privacy

Our dental office falls under the **PRIVACY STANDARDS** portion of the regulations because we transmit some health insurance information (insurance claims) electronically.

Part of the regulations require that we provide you with the accompanying form (**NOTICE OF PRIVACY PRACTICES**) and ask that you acknowledge that we have given the **NOTICE** to you for review by signing and dating the **ACKNOWLEDGEMENT** form.

The information basically tells you that we will not use your health information for any marketing purposes without your express permission. It goes on to describe your rights as a patient, namely:

- the right to access and copy your dental records
- the right to amend the information in your dental records
- the right to an accounting of non-routine or non-authorized disclosures
- the right to complain to our office or to the Secretary of Health and Human Services

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Patient's Name

_____ _____

Signature (if under 18 years of age, must be signed by parent or legal guardian) Date

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communications barrier prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement

MEDICAL HISTORY

Patient Name: _____ **Birth Date:_____**

Preferred Name:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all the following questions.

If you mark "Yes" to any of the following questions, please provide more information to the right of the question.		
Are you under a physician's care now? If so, please list their name and phone number.	❍ Yes ❍ No	
Have you ever been hospitalized or had a major operation?	❍ Yes ❍ No	
Are you taking any medications, pills, or drugs? Please list medications	❍ Yes ❍ No	
Do you take, or have you taken, Phen-Fen or Redux?	❍ Yes ❍ No	
Have you ever taken Fosamax, Boniva, Reclast, Actonel or any other medications containing bisphosphonates?	❍ Yes ❍ No	
Are you on a special diet?	❍ Yes ❍ No	
Do you have a Neurologic Condition (Ex: Add/Depression/MS)	❍ Yes ❍ No	
Do you use tobacco?	❍ Yes ❍ No	

Are you allergic to any of the following?

❍ Aspirin	❍ Metal	❍ Acrylic	❍ Codeine
❍ Ibuprofen	❍ Latex	❍ Local Anesthetics	❍ Acetaminophen
❍ Penicillin	❍ Sulfa Drugs	❍ No Known Allergies	

If any other allergy, please list:_____

Women: Are you…

❍ Pregnant/Trying to get pregnant ❍ Nursing ❍ Taking oral contraceptives

-Please fill out back as well-

Do you have, or have you had, any of the following? If yes, please describe in the Additional Information Box.

HEART/HEMATOLOGY

- ❍ Anemia
- ❍ Angina, Chest Pains
- ❍ Artificial Heart Valve
- ❍ Blood Disease/Disorder
- ❍ Blood Transfusion
- ❍ Bruise Easily
- ❍ Congenital Heart Disorder
- ❍ Excessive Bleeding
- ❍ Fainting/Syncope/ Dizziness
- ❍ Heart Attack/Failure
- ❍ Heart Murmur
- ❍ Heart Pacemaker
- ❍ Heart Stent
- ❍ Heart Trouble/Disease
- ❍ Hemophilia
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Infective Endocarditis
- ❍ Irregular Heartbeat
- ❍ Low Blood Pressure
- ❍ Mitral Valve Prolapse
- ❍ Sickle Cell Disease
- ❍ Stroke
- ❍ Swelling of Limbs

RESPIRATORY

- ❍ Anaphylaxis
- ❍ Asthma
- ❍ Breathing Problem
- ❍ Emphysema
- ❍ Hay Fever
- ❍ Lung/ Respiratory Disease
- ❍ Sinus Trouble
- ❍ Sleep Disorder
- ❍ Snoring

ENDOCRINE

- ❍ Diabetes (List HbA1c: _____)
- ❍ Glaucoma
- ❍ Hormone Deficiency
- ❍ Hypoglycemia
- ❍ Kidney Problems
- ❍ Liver Disease/ Jaundice
- ❍ Parathyroid Disease
- ❍ Renal Dialysis
- ❍ Thyroid Disease

INFECTIONS

- ❍ AIDS/HIV
- ❍ Cold Sores/Fever Blisters
- ❍ Hepatitis (Specify Type in Comments)
- ❍ Herpes
- ❍ Hives/Rash
- ❍ Rheumatic/ Scarlet Fever
- ❍ Shingles
- ❍ STD
- ❍ Tonsillitis
- ❍ Tuberculosis

DIGESTIVE

- ❍ Digestive Disorders (Celiac/Gastric Reflux)
- ❍ Stomach/Intestinal Disease
- ❍ Ulcers
- ❍ Frequent Diarrhea
- ❍ Jaw Pain

ONCOLOGY

- ❍ Cancer/ Tumors/ Growths
- ❍ Chemotherapy/ Immunosuppression
- ❍ Radiation treatments
- ❍ Recent Weight Loss

MENTAL HEALTH

- ❍ Alzheimer's Disease
- ❍ Drug Addiction
- ❍ Epilepsy/ Seizures/ Convulsions
- ❍ Frequent Headaches
- ❍ Mental Handicap
- ❍ Psychiatric Care
- ❍ Anxiety (Dental or Other)

JOINTS

- ❍ Arthritis/Gout/Lupus
- ❍ Artificial Joint
- ❍ Cortisone Medicine
- ❍ Head or Neck Injury
- ❍ Osteoporosis/ Osteopenia
- ❍ Rheumatism

List any serious illness not mentioned on this page:

Comments and Additional Information:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ **Date:**_____

Signature of Patient, Parent or Guardian

James Skoumal, D.D.S. PC.

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REGISTRATION AND HEALTH HISTORY

Today's Date_____ Date of Birth _____

Patient Name_____ Preferred Name _____

Home #_____ Cell #_____ SS # _____

Home Address_____ City _____ State____ Zip_____

Email Address_____

Ok to receive electronic communication Text ( ) Email ( )

Martial Status: Minor ( ) (Parents' Names) _____

Married ( ) (Spouse's Name) _____

Single ( ) Separated ( ) Divorced ( ) Widow ( ) Widower ( )

Whom may we thank for referring you to our office?_____

Patient's Employer_____ Phone_____

or Father's if patient is minor

Address_____

City_____ State_____ Zip_____

Occupation_____ SS#_____ Drivers License #_____

Dental Insurance Yes ( ) No ( ) Insured name and date of birth_____

I hereby authorize payment of the dental benefits, otherwise payable to me directly, to **Dr. James Skoumal, D.D.S. PC.**

_____ _____

Signed (Insured Person) Date

Patient's Employer_____ Phone_____

or Mother's if patient is minor

Address_____

City_____ State_____ Zip_____

Occupation_____ SS#_____ Drivers License #_____

Dental Insurance Yes ( ) No ( ) Insured name and date of birth_____

I hereby authorize payment of the dental benefits, otherwise payable to me directly, to **Dr. James Skoumal, D.D.S. PC.**

_____ _____

Signed (Insured Person) Date

Emergency Contact Name_____ Relation_____ Phone #_____